

BlueChoice[®]

Healthcare Plan

SUMMARY PLAN DESCRIPTION

For

STATE HEALTH BENEFIT PLAN

Administered By



NOTICE

This document, which is called the **Summary Plan Description (SPD) Booklet**, describes the health plan (herein called the Plan) as established by **State Health Benefit Plan** (herein called the Employer or Plan Sponsor).

This SPD Booklet is a part of the Employer's **Health Plan Document** which Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) (herein called the Claims Administrator), An Independent Licensee of the Blue Cross and Blue Shield Association, administers under the Employer's Self funded Plan.

Every effort has been made to accurately describe the Plan in this SPD Booklet. However, if there should be a discrepancy between this SPD Booklet and the Health Plan Document, or if the Plan is required to operate in a different manner to comply with federal laws and regulations, the Health Plan Document or the appropriate federal laws and regulations will govern.

Important: This is not an insured benefit plan. The benefits described in this SPD Booklet or any rider attached hereto are self-insured by the Employer which is responsible for their payment. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. provides claim administration services for the Plan, but Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. does not insure the benefits described.

Table of Contents

Summary of Benefits	ii
Eligibility	1
How Benefits Work	3
Pre-Admission Certification (PAC)	4
Benefits	4
Network Mental Health Care and Substance Abuse Treatment.....	14
Exclusions.....	15
Coordination of Benefits (COB).....	18
Subrogation.....	19
General Information	20
When Your Coverage Terminates	22
Definitions	27

BlueChoice Healthcare Plan (HMO)

All care must be received from or coordinated through your Primary Care Physician. A Participant has Direct Access to some specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist, a chiropractor; and an optometrist or ophthalmologist for medical conditions only.

All In-Network primary care must be received from the Primary Care Physician.

Lifetime Maximum Benefits (including Mental Health Care & Substance Abuse Treatment) \$2,000,000

Percentage Payable (Unless Otherwise Specified) 90%

All payments are based on Eligible Charges and negotiated arrangements.

Calendar Year Deductible

Under Family Coverage, a Participant cannot meet more than the Individual Deductible

Individual \$200

Family..... \$400

Out-of-Pocket Limit Per Calendar Year (including Deductible)

Under Family Coverage, a Participant cannot meet more than the Individual Out-of-Pocket Limit

Individual \$1,000

Family..... \$2,000

Hospital Inpatient Services (subject to Deductible)

Room and Board (Semi-Private or ICU/CCU) 90%

Hospital Services and Supplies (x-ray, lab, anesthesia, etc.)..... 90%

Physician Services (Well Newborn Care) 100%

Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 90%

Outpatient Hospital Services (subject to Deductible)

Outpatient Surgery Facility, etc..... 90%

Outpatient Lab, X-ray and Anesthesia Services 90%

Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 90%

Emergency Room Copayment

Life-threatening medical conditions or serious Accidental Injuries \$100

The emergency room Copayment is waived if you are admitted to the Hospital through the emergency room.

Coverage is provided on a 24-hour basis for these services. Follow-up care must be coordinated through the Primary Care Physician.

Primary Care Physician notification, if not completed prior to emergency room visit, must occur within 48 hours of seeking emergency room care.

Non-emergency use of the emergency room is **NOT** covered.

BlueChoice Healthcare Plan (HMO)

Inpatient Mental Health Care and Substance Abuse Treatment (Not subject to Deductible)

Days/Visits Maximum Per Calendar Year	30
Hospital Inpatient Services	90%
Physician Hospital Services.....	90%

Inpatient Substance Abuse Detoxification.....90%
3 days per Calendar Year maximum (part of the 30 days per Calendar Year Inpatient Mental Health Care benefit)

Outpatient Mental Health Care and Substance Abuse Treatment

Maximum visits per Calendar Year.....	25
Per visit Copayment	\$25

Physician Office Services Copayment

Primary Care Physician, per office visit.....	\$20
Outpatient Surgery in Physician's office	
Immunizations	
Periodic Health Assessment	

After Hours Primary Care Physician Copayment	\$25
--	------

Specialist Physician (needs Primary Care Physician referral)

Specialist Physician (needs Primary Care Physician referral)	\$25
Allergy office visits, shots, serum	
Allergy Testing	
Dermatologist Services (PCP referral not required)	
Maternity Care Visits (first visit only) (PCP referral not required)	
Outpatient Surgery in Physician's office	
Physical/Occupational Therapy: 40 visits per Calendar Year	
Speech Therapy: 40 visits per Calendar Year	
Vision Care Services (excluding routine vision care)(PCP referral not required)	
Services must be provided by a network ophthalmologist or optometrist	
for the treatment of acute conditions only	

Outpatient Acute Short-Term Rehabilitation Services

Copayment per visit.....	\$25
Maximum visits per Calendar Year.....	40

Chiropractic Rider (PCP referral not required).....

Spinal Manipulation, 20 visits per Calendar Year, one treatment per day.

Prescription Drugs (30-day supply from participating pharmacies)

Prescription Drug Copayment (Generic in Formulary), per prescription	\$10
Prescription Drug Copayment (Brand Name in Formulary), per prescription.....	\$25
Prescription Drug Copayment (Brand Name not in Formulary), per prescription	\$50

Maintenance Prescription Drugs (90-day supply from participating pharmacies)

Prescription Drug Copayment (Generic in Formulary), per prescription	\$20
Prescription Drug Copayment (Brand Name in Formulary), per prescription.....	\$50
Prescription Drug Copayment (Brand Name not in Formulary), per prescription	\$100

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Note: In-Network benefits are not paid for Prescriptions written by an Out-of-Network Provider.

BlueChoice Healthcare Plan (HMO)

Special Features:

- **Ambulance Service** (when Medically Necessary)100%
- **Durable Medical Equipment (DME)** (when Medically Necessary).....100%
- **Home Health Care Services:** 120 visits per Calendar Year100%
- **Hospice Care Services:** \$10,000 lifetime maximum (prior approval required).....100%
- **Radiation Therapy, Chemotherapy**100%
- **Skilled Nursing Facility:** 45 days per Calendar Year (prior approval required)(subject to Deductible)90%
- **Transplant Services:** (subject to Deductible)90%

Types of Coverage

The type of coverage is determined by the Employee's selection at the time of enrollment through the Employer.

Note: These benefits are valid for the Employer's current benefit period. The Employee will receive a revised Summary of Benefits if there is a change in Plan benefits.

BlueChoice Healthcare Plan (HMO)

Summary Notice

This SPD Booklet summarizes your Employer's health care benefit Plan. It is the benefit portion of the Health Plan Document, which governs the Plan's coverage. The Health Plan Document, and any riders and/or amendments comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this SPD Booklets carefully. If you have any questions about your benefits as presented in this SPD Booklets, please contact your Employer's Plan Administrator or call the Claims Administrator's Customer Service Department.

This SPD Booklets makes up the Covered Services provisions of the Health Plan Document. Its purpose is to help you understand your coverage and to provide an explanation of the benefits that the Employer offers. Further terms and conditions of the health care coverage and other benefits are contained in the Health Plan Document. A copy of the Health Plan Document is held by your Employer; however, this SPD Booklet provides the health benefits for easy reference.

Important: This is not an insured benefit plan. The benefits described in this SPD Booklet or any rider attached hereto are self-insured by the Employer which is responsible for their payment. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. provides claim administration services to the Plan, but Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. does not insure the benefits described.

All care must be received from or coordinated through your Primary Care Physician. A Participant has Direct Access to some specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological-related conditions; a dermatologist, a chiropractor; and an optometrist or ophthalmologist for medical conditions only.

All In-Network primary care must be received from your Primary Care Physician.

A woman may refer herself directly to a BlueChoice Healthcare Plan gynecologist for obstetrical or gynecological-related conditions; a Primary Care Physician Referral is not required.

A Participant may go directly to a BlueChoice Healthcare Plan dermatologist; a Primary Care Physician Referral is not required.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-800-292-2879; a Primary Care Physician Referral is not required.

A Participant who seeks eye care may obtain such service directly from a BlueChoice Healthcare Plan ophthalmologist or optometrist who is licensed to provide eye care. This self-referral is for medical conditions only, not routine vision care.

When You're Away From Home

If you're away from the Service Area on business or pleasure, you still have coverage for Medical Emergencies. If you have a Medical Emergency, go to the nearest Hospital emergency room for treatment. If you're outside of the Service Area, you'll have to pay for any treatment you receive. You will be reimbursed except for any required Copayment or Out-of-Pocket amount. You will need a copy of any bills. Call Customer Service as soon as it's convenient and one of the representatives will tell you what you should do.

Should your treatment require you to be hospitalized, call the Customer Service Department or have someone call for you within 48 hours.

BlueChoice Healthcare Plan (HMO)

Important Phone Numbers

Pre-Admission Certification (PAC)

You should call your Primary Care Physician.

Your Primary Care Physician or the Hospital should call the following number for Pre-Admission Certification

- Atlanta Calling Area (404) 237-2429
- All Other Areas 1-800-662-9023 or 1-800-722-6614

Customer Service

If you have a Customer-Service question, please call:

- 1-800-464-1367

To locate a network provider, review wellness information and more, please visit us at www.bcbsga.com.

Mental Health Care or Substance Abuse Treatment

You may access the mental health network in complete confidence by calling:

- 1-800-292-2879

Health Improvement Resource

For preventive health and wellness information for you and your family, call the Health Improvement Resource line 24 hours a day at:

- 1-800-638-4754

Please have your ID number available when you call. Requested information will be sent free of charge.

BlueChoice On-Call

A 7-day-a-week, 24 hour a day service available for all covered family members. When you or a covered family member is experiencing health symptoms, you may call BlueChoice On-Call to speak to a registered nurse. The nurse will provide information to help you decide on the most appropriate treatment or care. You may also listen to a variety of medical audio tapes or request written information on a variety of conditions.

- 1-888-724-BLUE (2583)

Special Phone Numbers

Please check your ID card for telephone numbers unique to your Group.

BlueChoice Healthcare Plan (HMO)

Eligibility

Coverage for the Employee

This SPD Booklet describes the benefits the Employee may receive under this health care Plan. The Employee is also called a Participant.

Coverage for the Employee's Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Participants.

If the wrong birthdate of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either the Employee or the Plan.

Eligible Dependents Include:

- The Employee's Spouse (For the purpose of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Employee);
- The Employee's unmarried dependent children until attaining age 19, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree. Children may be covered until attaining age 26 provided they remain the Employee's Dependents and, in each Calendar Year since reaching age 19, are enrolled as full-time students in a post-secondary institution of higher learning for five calendar months or more; or, if not enrolled, would have been eligible to enroll, but were prevented due to illness or Injury.
- Unmarried children who are mentally or physically handicapped and totally dependent on the Employee for support, regardless of age with the exception of incapacitated children age 19 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan or prior Creditable Coverage prior to reaching age 19. Certification of the handicap is required within 31 days of attainment of age 19. A certification form is available from the Employer or from the Claims Administrator and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Initial Enrollees

Initial Enrollees and eligible Dependents, who were previously enrolled under group coverage which this Plan replaces, are eligible for coverage on the Effective Date of this coverage. Any waiting periods which were not satisfied under previous Creditable Coverage must be satisfied under this Plan. However, credit will be given for the length of time already served.

New Hires

Applications for enrollment must be submitted within 31 days from the date the Employee is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee and the Employee's Dependents will be treated as Late Enrollees. Please refer to the "**Late Enrollees**" provision listed below.

Late Enrollees

If the Employee or the Employee's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

1. Originally declined coverage because of other coverage, and
2. Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.
3. An individual who declined coverage must have certified in writing that he or she was covered by another health plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when he or she originally declines coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions. An unenrolled Participant may enroll within 31 days of such a special qualifying event.

Important Notes:

1. Individuals enrolled during special enrollment periods are **not** Late Enrollees.
2. Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

BlueChoice Healthcare Plan (HMO)

3. Evidence of prior Creditable Coverage is required and must be furnished by the Employee or the Employee's prior carrier.

When Coverage Begins

If the Employee applies when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage

There may be an annual re-enrollment period during which time Participants may elect to change their options.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

As the Employee's family increases, the Employee may add new Dependents by contacting the Plan Administrator. The Employee or the Plan Administrator must notify the Claims Administrator in writing. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents who have been reported to the Claims Administrator and added to the coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31-days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage. Remember, there will be an additional charge.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31-days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the "**Late Enrollees**" provision in this section.

Newborn and Adopted Children

A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility up to age 19. If additional Premium is required to continue coverage beyond the 31-day period, the Employee must notify the Claims Administrator of the birth or adoption and pay the required Premium within the 31-day period or coverage will terminate. Types of coverage requiring additional Premium include One-Person Coverage and Two-Person Coverage.

If an Employee has Family Coverage or Multi-Person Coverage, no additional Premium is required and coverage automatically continues. However, the Employee should notify the Claims Administrator of the birth or adoption within 31-days to ensure accurate records and timely payment of claims.

Extending coverage for a newborn child or an adopted child being added to One-Person or Two-Person Coverage beyond the 31-day period requires Late Enrollment. Please refer to the "**Late Enrollees**" provision in this section.

Foster Children

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom an Employee assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, an Employee must provide confirmation of a valid foster parent relationship to the Claims Administrator. Such confirmation must be furnished at the Employee's expense. When the application is processed, the Effective Date will be the first of the month following your Employer's Employee waiting period.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
 - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a "Medical Child Support Order") which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
 - Upon receipt of an MCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will

BlueChoice Healthcare Plan (HMO)

explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 19 or marries (see "When Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

New Hires

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Group but not currently active due to health status.

Portability Provision

Any newly eligible Employee, Participant, Enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 63 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision the Employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Plan.

How Benefits Work

Note: Capitalized terms such as Covered Services, Medical Necessity, Network Hospitals and Out-of-Pocket Limit are defined in the "Definitions" section.

Introduction

BlueChoice Healthcare Plan is a comprehensive plan that provides Primary and Referral health care services. All In-Network Care must be received from or coordinated through your Primary Care Physician. Direct Access In-Network is available for a gynecologist for obstetrical or gynecological-related conditions, a dermatologist, a chiropractor, and an optometrist or ophthalmologist for medical conditions only. All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Physicians and Hospitals participating in BCBSHP's networks are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement.

Eligible Charges

For In-Network services, Eligible Charges are determined by: (a) BCBSHP's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) BCBSHP's Usual, Customary and Reasonable (UCR) Fees; (b) a Provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. Reimbursement for Out-of-Network, Participating and Non-Participating Providers is based on Eligible Charges for the type of service a Participant receives, for example, Hospital or Physician services.

Copayment

An Employee will be charged a Copayment amount for certain services; the Copayment amount may be a flat-dollar amount or a percentage of the total charge. Copayment amounts are shown in the **Summary of Benefits**. The emergency room Copayment is waived if an Employee is admitted to the Hospital through the emergency room.

Calendar Year Deductible

Before your program begins to pay benefits, you must meet any **Deductible** required. Deductible requirements are stated in the **Summary of Benefits**.

BlueChoice Healthcare Plan (HMO)

Coinsurance and Out-of-Pocket Limit

The **percentage payable** by the Claims Administrator is stated in the **Summary of Benefits**. The portion which you must pay (the Coinsurance) is stated in the **Summary of Benefits**. After you reach your Out-of-Pocket Limit, (including any required Deductible), your Plan pays 100% of Eligible Charges for the remainder of the Calendar Year. The Out-of-Pocket Limit benefit does not apply to any Copayment.

Mental Health Care and Substance Abuse Treatment

The **percentage payable** for Mental Health Care and Substance Abuse Treatment is stated in the **Summary of Benefits**. Limitations, if any, are stated in the **Summary of Benefits**.

Pre-Admission Certification (PAC)

Hospital Pre-certification

The Pre-Admission Certification Process

- Length-of-Stay Assignment indicates the number of Inpatient days usually Medically Necessary to treat a condition;
- Continued Stay Review/Concurrent Review determines whether a continued Inpatient stay is Medically Necessary;

If your stay exceeds the number of days assigned under this Plan, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all Primary Care Physician or Referral Specialist guidelines are followed, you will not be responsible for any eligible Hospital charge in excess of any applicable Copayment or Coinsurance amounts.

- Admission Review determines whether an unscheduled Inpatient admission or an admission not subject to pre-certification was Medically Necessary;
- Discharge Planning assesses the Participant's need for additional treatment after Hospital discharge.

In-Network Care

- If you are hospitalized other than in a Medical Emergency and pre-admission certification was not obtained, all charges will be denied. You will be held harmless if all Network guidelines are followed. This means you will not be responsible for any bill in excess of the Copayments or Coinsurance that apply.
- Ineligible Charges and Non-Covered Services are always the Participant's responsibility.
- PAC is the responsibility of the admitting Physician.

Pre-Admission Certification is not a guarantee of payment

Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the Effective Date for any Participant, and also will be dependent on, but not limited to, specific Group coverage and the status of the coverage on the date services are rendered. The Plan will not cover services related to specific Plan exclusions and limitations, including but not limited to, Custodial Care, Experimental and Investigational procedures and services determined not Medically Necessary.

Benefits

All Covered Services must be Medically Necessary.

Primary Care Physician (PCP)

All In-Network Care must be received from or coordinated through your Primary Care Physician (PCP). A Participant has Direct Access to some specified In-Network Providers without a Primary Care Physician Referral. Such Providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist; a chiropractor and an optometrist or ophthalmologist for medical conditions only.

PCPs are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a Participant becomes sick or is injured after the PCP's regular office hours, the Participant should:

- call the PCP's office; and
- identify himself or herself as a Participant; and
- follow the PCP's or covering Physician's instructions.

If the Participant's Injury or illness is a Medical Emergency, the Participant should follow the procedures outlined under the Medical Emergency Care section.

BlueChoice Healthcare Plan (HMO)

Payment terms apply to all Covered Services. The following services are covered, if Medically Necessary. Please refer to the **Summary of Benefits** for payment explanations.

Specialist Physician

Your Primary Care Physician will refer you to a Specialist for appropriate care when necessary.

The specialist Physician will need to coordinate continuing care with your Primary Care Physician if either of the following two recommendations is made after your visit:

- Additional care by the Specialist Physician is required;
- A Referral for another type of care is indicated.

Physician Services

Covered Services include the following:

In-Network visits to a Physician's office are subject to the per-visit Copayment indicated in the **Summary of Benefits**.

In-Network Preventive Care

The following services are Covered Services only if performed In-Network by your Primary Care Physician or by an obstetrician or gynecologist who is a Network Physician:

- Visits to a Physician's office are subject to the per visit Copayment indicated in the **Summary of Benefits**. Covered Services in the Physician's office include, but are not limited to:
 - Treatment or preventive services including periodic health examinations for adults and well-child care services for Dependent children under the age of 19.
 - Family planning services and services for infertility subject to listed exclusions.
 - Immunizations in accordance with established age appropriate preventive health guidelines, exclusive of immunizations suggested for travel or required for employment.
 - Prenatal care visits. Only one (1) Copayment for all visits combined will be charged.
 - Benefits will be provided for one mammogram and one pap smear tissue examination per year, or more often when ordered by a Physician.
 - Benefits will be provided for annual prostate specific antigen tests for covered males who are 45 years of age or older; or covered males who are 40 years of age or older if ordered by a Physician.

- Benefits will be provided for one annual chlamydia screening test for covered females who are not more than 29 years old.

Urgent Care Services

Services rendered at contracted Urgent Care Centers are covered if the Participant is referred by the Participant's Primary Care Physician.

Network Hospital Services

For In-Network care, your Physician must arrange your admission. Your Plan provides Covered Services when the following services are Medically Necessary.

The following Hospital services are covered.

In-Patient Hospital Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Eligible Charges are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Eligible Charges are based on the Hospital's prevalent room rate.

Service and Supplies

- Your benefits cover services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation therapy, speech therapy and occupational therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient Hospital Services

Outpatient Services

Your Plan provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require pre-certification from the Claims Administrator.

BlueChoice Healthcare Plan (HMO)

Medical Emergency Care

- Life-threatening emergency care or treatment for a Medical Emergency is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life-threatening Medical Emergency. See “Definitions”.
- The emergency room Copayment is required for initial services for Medical Emergencies rendered in the emergency room of a Hospital. Primary Care Physician notification, if not completed prior to emergency room visit, should occur within 48 hours of seeking emergency room care.
- Use of the emergency room for conditions that are not Medical Emergencies is **not** covered.
- A Participant is responsible for the required Copayment which is waived if a Participant is admitted to the Hospital through the emergency room.
- Covered Services for Medical Emergencies include Medically Necessary mental health emergency care provided in the emergency room. This service is not limited by the twenty (20) outpatient In-Network visit limitation. Emergency care coverage includes care related to Medical Emergencies associated with Substance Abuse.
- Follow-up care must be coordinated by your Primary Care Physician.

Other Covered Services

The Plan provides Covered Services when the following services are Medically Necessary:

Medical and Surgical Care

General care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Assistant Surgery

If Medically Necessary, services rendered by an assistant surgeon are covered in conjunction with a surgery which has been coordinated by the Participant’s surgeon.

Registered Nurse First Assistant

Covered Services are provided for eligible registered nurse first assistants. Benefits are payable directly to a registered nurse first assistant if such services are payable to a surgical first assistant and such services are performed at the request of a Physician and within the scope of a registered nurse first assistant’s professional license. No benefits are payable to a registered nurse first assistant who is employed by a Physician or a Hospital.

Reconstructive Surgery

Pre-certification is required. Reconstructive Surgery does not include any service otherwise excluded in this SPD Booklets. (See “Exclusions”.)

Reconstructive Surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes;
- To correct congenital defects of a dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Breast Cancer Patient Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Participant. Follow-up visits are also included and may be conducted at home or at the Physician’s office as determined by the attending Physician in consultation with the Participant.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Ovarian Cancer Surveillance Tests

Covered Services are provided for risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolyposis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

Nutritional Counseling for Obesity

Covered Services for obesity include up to two nutritional counseling visits when referred by your Primary Care Physician. Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

BlueChoice Healthcare Plan (HMO)

Second Medical Opinion

Covered Services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or, when pre-certified by the Claims Administrator, any medical care that is a Covered Service.

Oral Surgery

Pre-certification is required and must be obtained by the Participant from a Network Physician.

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth and associated hospitalization. Pre-certification is required and must be obtained by the Participant from a Network Physician;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Participant is covered by this Plan and performed within 180 days after the accident.

Non-Participating/Freestanding Ambulatory Facility

Any services rendered or supplies provided while you are a patient or receives services at or from a Non-Participating Freestanding Ambulatory Facility will be payable at 50% of Eligible Charges.

Hospital Visits

The Physician's visits to his or her patient in the Hospital.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Anesthesia Services for Certain Dental Patients

General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

- patients age 7 or younger or developmentally disabled.
- an individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder.
- an individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Pre-certification is required.

Use of Operating and Treatment Rooms and Equipment

Medical Treatment of Attention Deficit Disorder

Drugs may be prescribed by your Primary Care Physician. Only legend Prescription Drugs will be covered.

Diagnostic X-ray and Laboratory Procedures

Chemotherapy and Radioisotope, Radiation and Nuclear Medicine Therapy

Oxygen, Blood and Components, and Administration

Dressings, Splints, Casts when provided by a covered Physician.

BlueChoice Healthcare Plan (HMO)

Clinical Trial Programs for Treatment of Children's Cancer

Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and benefits to Participants who are dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care costs mean those pre-certified as Medically Necessary costs as provided in Georgia law (OCGA 33-24-59.1)

Colorectal Cancer Examinations and Laboratory Tests

Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Participants who are 50 years of age or older and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.

Diabetes

Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Osteoporosis

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Participants meeting BCBSHP's criteria.

Prescription Drugs

Covered Services are stated in the **Summary of Benefits**. All In-Network prescriptions must be written by either your Primary Care Physician, a Network Physician designated by your Primary Care Physician to provide services in his/her absence, an emergency room Physician (if your condition is a Medical Emergency), or a Specialist who is a Network Provider.

Your benefit design as shown in the **Summary of Benefits** will determine the Copayment of your Prescription Drug Plan for Formulary drugs and non-formulary drugs.

Covered Services may include:

Retail Prescription Drugs that have been prescribed by a Network Provider and obtained through a participating pharmacy. Retail Prescription Drugs shall, in all cases, be dispensed according to the Drug Formulary for prescriptions written and filled In-Network. The Drug Formulary may be amended from time to time by BCBSHP.

A Participant or prospective Participant shall be entitled upon request, to a copy of the Drug Formulary Guide, available through the Member Guide or BCBSHP's Website. You may exercise your right to a non-formulary drug by filing a Formulary appeal.

You can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Formulary when:

- The Formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or
- The Formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.

Maintenance drugs are available in a 90-day supply from a participating pharmacy. To determine if a drug is considered a maintenance drug or requires pre-authorization, please call Customer Service. If a particular drug is not on the list of maintenance drugs, then it is not allowed for a 90-day supply at a participating pharmacy.

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug benefit when accompanied by a prescription.

The following are not Covered Services under this Plan:

1. Prescription Drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule.
2. Prescription Drugs received through an Internet pharmacy provider or mail order provider.
3. Non-legend vitamins.
4. Smoking cessation products (including the use of Wellbutrin SR for this purpose).
5. Over-the-counter items.
6. Cosmetic drugs (e.g., Propecia).
7. Appetite suppressants (anorexiant).
8. Weight loss products.
9. Diet supplements.
10. Syringes (for use other than insulin).

BlueChoice Healthcare Plan (HMO)

11. Non-contraceptive injectables (except with pre-certification).
12. The administration or injection of any Prescription Drug or any drugs or medicines.
13. Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
14. Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
15. Prescription Drugs for which there is no charge.
16. Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
17. Prescription Drugs for use as an Inpatient or outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
18. Charges for delivery of any Prescription Drugs.
19. Drugs and medicines which do not require a prescription order and which are not Prescription Drugs.
20. Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
21. Prescription Drugs which are not Medically Necessary or which the Plan Administrator determines are not consistent with the diagnosis.
22. Prescription Drugs which the Plan Administrator determines are not provided in accordance with accepted professional medical standards in the United States.
23. Any services or supplies which are not specifically listed as covered under this Prescription Drug Plan.
24. Prescription Drugs which are Experimental or Investigational in nature as explained in the "Exclusions" section.

Nutritional Counseling

Nutritional counseling related to the medical management of certain disease states (subject to pre-certification by the Claims Administrator).

Cardiac Rehabilitation

Programs require prior authorization and Individual Case Management.

Allergy conditions

Benefits are provided as stated in the **Summary of Benefits**.

Durable Medical Equipment

In addition to meeting criteria for Medical Necessity and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed

part of the body or to prevent or slow further decline of the Participant's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan Administrator may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patient's physical disorder.

Dialysis Treatment

Dialysis treatment is covered if care has been pre-certified by and coordinated through your Primary Care Physician. The Plan Administrator will pay secondary to Medicare Part B, even if a Participant has not applied for eligible coverage available through Medicare.

Ambulance Service

Local service to a Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary whether you are in or out of BCBSHP's Service Area. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

The following items related to prosthetic devices include artificial limbs and accessories, artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s), arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal.

The following items are **excluded**: corrective shoes; dentures; replacement of teeth or structures directly supporting teeth except to correct traumatic injuries; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; or implants for cosmetic purposes except for reconstruction following a mastectomy.

BlueChoice Healthcare Plan (HMO)

Physical Therapy/Occupational Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), limited to a combined total maximum visits per Calendar Year as outlined in the **Summary of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Chiropractic Care

Covered Services for In-Network spinal manipulation are covered as stated in the **Summary of Benefits**.

Licensed Speech Therapist Services

The visits must be pre-certified by the Claims Administrator. Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits**. Developmental Delay will be covered when it is more than two standard deviations from the norm as defined by standardized, validated developmental screening tests such as the Denver Developmental Screening Test. Services will be covered only to treat or promote recovery of the specific functional deficits identified.

Maternity Care

Covered Services include Maternity Care on the same basis as for any other type of care, subject to your Plan's Copayment and/or percentage payable provisions.

Maternity benefits are provided for a female Employee and any eligible female Dependent.

Routine newborn nursery care is part of the mother's maternity benefits. The newborn pediatrician visit in the Hospital is covered In-Network.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name (see "Changing Coverage" to add coverage for a newborn).

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require prior certification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the mother's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the mother will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may

be provided either in the Physician's office or in the mother's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the mother's attending Physician.

Prenatal care visits: only one (1) Copayment for all visits combined will be charged.

Complications of Pregnancy

Benefits are provided for Complications of Pregnancy (see "Definitions"), resulting from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but are adversely affected or caused by pregnancy.

Benefits for a normal or difficult delivery are not covered under this provision. Such benefits are determined solely by the maternity section of this Plan.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Summary of Benefits**. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Participant stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

BlueChoice Healthcare Plan (HMO)

Benefits will not be provided when:

- A Participant reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Participant is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Home Health Care Services

Home Health Care provides a program for the Participant's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits**. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending Physician.

Covered Services Include:

1. Visits by an RN or LPN - Benefits cannot be provided for services if the nurse is related to the Participant.
2. Visits by a qualified physiotherapist, speech therapist or by an inhalation therapist certified by the National Board of Respiratory Therapy.
3. Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social, and environmental factors resulting from or affecting the Participant's illness.
4. Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
5. Administration of prescribed drugs.
6. Oxygen and its administration.

Covered Services for Home Health Care do not include:

1. Food, housing, homemaker services, sitters, home-delivered meals.
2. Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
3. Services and/or supplies which are not included in the Home Health Care plan as described.
4. Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse.

5. Any services for any period during which the Participant is not under the continuing care of a Physician.
6. Convalescent or Custodial Care where the Participant has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
7. Any services or supplies not specifically listed as Covered Services.
8. Routine care and/or examination of a newborn child.
9. Dietitian services.
10. Maintenance therapy.
11. Dialysis treatment.
12. Purchase or rental of dialysis equipment.
13. Private duty nursing care.

Hospice Care Services

Hospice benefits cover Inpatient and outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Plan provides Covered Services for Inpatient and outpatient Hospice care under certain conditions as stated in the **Summary of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by the Claims Administration;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
 - provides an organized system of home care;
 - uses a Hospice team; and
 - has around-the-clock care available.

Individual Case Management

The individual case management program is designed to ensure and provide payment of benefits to eligible Participants who, with their attending Physician, agree to treatment under an Alternative Benefit Plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each Plan Participant.

The program includes:

- the identification of potential program participants through active casefinding and referral mechanisms;
- eligibility screening;
- preparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

BlueChoice Healthcare Plan (HMO)

Eligibility

A Participant receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Plan is responsible for determining eligibility for cases to be included in the program.

The Participant—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with the Claims Administrator the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. The Plan Administrator will determine the maximum approved payments allowable under the Plan.

Benefits under the Plan are furnished as an alternative to other Plan benefits and are limited to the following:

1. Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Participant.
2. Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
3. When necessary for the long term care of the Participant in the home-setting, Respite Care to relieve family members or other persons caring for the Participant at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. The Plan Claims may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Participant's remaining available benefits under the Plan.)

The Participant must obtain pre-certification from the Claims Administrator regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at the Plan's discretion.

Covered Services

- Services covered under individual case management will be determined by the Plan on a case-by-case basis. Benefits may be provided for the rehabilitation of a Participant on an Inpatient, outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The program may provide or coordinate any of the types of Covered Services provided pursuant to this SPD Booklet.
- At its sole discretion, in the context of an individual case management program, the Plan may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this SPD Booklet; (ii) neither excluded nor defined as Covered Services under this SPD Booklet, or (iii) exceeding the maximum for any Covered Service under this SPD Booklet.

Utilization

- Benefits will be provided only when and for as long as the Plan deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits that may be paid will not exceed those which the Participant would have otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in BCBSHP sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

BlueChoice Healthcare Plan (HMO)

Individual Case Management Definitions

Case Manager

The person designated by the Claims Administrator to manage and coordinate the Participant's medical benefits under the individual case management program.

Provider

A Provider may be any facility or practitioner including, but not limited to Ineligible Providers, licensed or certified to give services or supplies consistent with the Plan of Treatment and approved by the Claims Administrator.

Termination of Individual Case Management

Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when:

1. Extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by the Plan Sponsor, due to a change in the patient's condition, or
2. The total amount of benefits paid for such services and for all other Covered Services equals the Lifetime Maximum Benefit.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this SPD Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Plan) and transplant related chemotherapy for cancer limited as follows.

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a "donor") and implanted in the body of another person (called a "recipient"); or
- removed from and replaced in the same person's body (called a "self-donor").

A covered transplant means a medically appropriate transplant of one of the following organs or tissues only and no others.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy are considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of :

- Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
- Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
- Neuroblastoma, Stage III or Stage IV;
- Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have HLA-compatible donor available for allogenic bone marrow support;
- Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
- Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
- Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
 - aplastic anemia;
 - acute leukemia;
 - severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
 - infantile malignant osteoporosis;
 - chronic myelogenous leukemia;
 - lymphoma (Wiscott-Aldrich syndrome);
 - lysosomal storage disorder;
 - myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it; and
- transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as nontransplant related under the terms of the Plan.

BlueChoice Healthcare Plan (HMO)

“Facility Transplant” means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.

“Medically Appropriate” means the recipient or self-donor meets the criteria for a transplant established by the Plan.

“Professional Provider Transplant Services” means all Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and antirejection drugs.

Benefits for Antirejection Drugs

For antirejection drugs following the covered transplant, the Plan will pay according to the benefits for Prescription Drugs, if any, under the Plan.

Pre-certification Requirement

All transplant procedures must be pre-certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by the Claims Administrator. To pre-certify, call the Claims Administrator’s office using the telephone number on your Identification Card.

The pre-certification requirements are a part of the benefit administration of the Plan and are not a treatment recommendation. The actual course of medical treatment the Participant chooses remains strictly a matter between the Participant and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by the Claims Administrator.

If the transplant involves a living donor, benefits are as follows:

- If a Participant receives a transplant and the donor is also covered under this Plan, payment for the Participant and the donor will be made under each individual’s coverage.
- If the donor is not covered under this Plan, payment for the Participant and the donor will be made under this Plan but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Participant is the donor and the recipient is not covered under this Plan, payment for the Participant will be made under this Plan limited by any payment

which might be made by the recipient’s hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

Please see the Exclusions section for Non-Covered Services.

Network Mental Health Care and Substance Abuse Treatment

Hospital Inpatient Mental Health Care & Substance Abuse Treatment

Benefits for Hospital and Physician Inpatient charges for each Participant are stated in the **Summary of Benefits**.

Hospital Inpatient Alcohol and Drug Detoxification

Benefits for acute alcohol and drug Detoxification for each Participant in a Network Hospital are stated in the **Summary of Benefits**.

Benefits for professional fees for Inpatient Physician treatment of acute alcohol and drug Detoxification for each Participant when administered by a Network Provider are stated in the **Summary of Benefits**.

Long term rehabilitation for chemical dependency is not covered. Treatment for physiological problems resulting from chemical dependency is covered as any other illness.

Professional Outpatient Mental Health Care and Substance Abuse Treatment

Benefits for outpatient charges for each Participant (50-55 minute sessions or their equivalent) are stated in the **Summary of Benefits**.

Other Medical Care Covered Services include:

- Professional care in the outpatient department of a Hospital;
- Physician’s office visits;
- Services within the lawful scope of practice of a licensed, approved Provider.

Limitations, if any, are stated in the **Summary of Benefits**.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-800-292-2879; a Primary Care Physician Referral is not required.

BlueChoice Healthcare Plan (HMO)

Exclusions

What's Not Covered

The Plan does not provide benefits for:

1. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness.
2. Services that are not Covered Services under the Plan, even when a prior Referral has been issued by a Primary Care Physician.
3. In-Network non-emergency care, supplies, or equipment that are not authorized by your Primary Care Physician or by other BCBSHP certification procedures, except that Participants have the right to Direct Access to specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological – related conditions, a dermatologist; and an optometrist/ophthalmologist for medical conditions only.
4. Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include, but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
5. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
6. Any portion of a provider's fee or charge which is ordinarily due from a Participant, but which has been waived. If a provider routinely waives (does not require the Participant to pay) an Out-of-Pocket amount, the Plan Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
7. Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.
8. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
9. Any item, service, supply or care not specifically listed as a Covered Service in this SPD Booklets.
10. Care given by a medical department or clinic run by your Employer.
11. Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
12. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoe (except when orthopedic shoes is joined to a brace).
13. Routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or a symptomatic complaints related to the feet.
14. Daily room charges while this Plan is paying for an Intensive care, cardiac care, or other special care unit.
15. Vision care services and supplies, including, but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
16. Hearing aids, hearing devices and related or routine examinations and services.
17. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this SPD Booklet.
18. The following items related to Durable Medical Equipment are specifically **excluded**:
 - Air conditioners, humidifiers, dehumidifiers, or purifiers;
 - Arch supports, or orthopedic or corrective shoes;
 - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
 - Sterile water;
 - Deluxe equipment, such as motor-driven chairs or beds, when standard equipment is adequate;
 - Rental or purchase of equipment if you are in a facility which provides such equipment;
 - Pools, spas, and whirlpools;
 - Electric stair chairs or elevator chairs;
 - Physical fitness, exercise, or ultraviolet/tanning equipment;
 - Residential structural modification to facilitate the use of equipment;
 - Other items of equipment that the Plan Administrator determines do not meet the listed criteria.
19. Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical

BlueChoice Healthcare Plan (HMO)

Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

20. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
21. Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
22. Care, supplies, or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards. Other non-covered items include household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs, the purchase or rental of exercise cycles, physical fitness, ultraviolet/tanning equipment, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
23. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, unless treatment relating to such consequences is Medically Necessary. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by the Claims Administrator are not covered.
 - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
 - This exclusion does not apply to Breast Reconstructive Surgery. Please see the Benefits section of this SPD Booklets.
24. Complications of non-covered procedures are not covered.
25. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this SPD Booklet.
26. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).
27. Surgical care or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
28. Transportation provided by other than a state licensed professional ambulance service, and ambulance services other than in a Medical Emergency.
29. Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
30. Advice or consultation given by any form of telecommunication.
31. Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in the Claims Administrator's judgement, Experimental or

BlueChoice Healthcare Plan (HMO)

Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

32. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
33. Charges for failure to keep a scheduled visit or completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
34. Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
35. Services for outpatient therapy or rehabilitation other than those specifically listed in this SPD Booklets. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.
36. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
37. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
38. Expenses in excess of Usual, Customary and Reasonable Fees (UCR) (as determined by BCBSHP).
39. Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or combination thereof.
40. Biofeedback, recreational, or educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
41. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guests' meals and accommodations, barber services, telephone

charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

42. Inpatient Hospital care for mental health conditions when the stay is:
 - determined to be court-ordered, custodial, or solely for the purpose of environmental control;
 - rendered in a home, halfway house, school, or domiciliary institution;
 - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations.
43. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan Administrator provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Neither physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
44. Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
 - the Treatment is for maintenance therapy; or
 - the Participant has no restorative potential; or
 - the treatment is for congenital learning or neurological disability/disorder; or
 - the treatment is for communication training, educational training or vocational training.
45. Injuries received while committing a crime.
46. Biomicroscopy, field charting or aniseikonic investigation.
47. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
48. Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Plan has

BlueChoice Healthcare Plan (HMO)

mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.

49. Non-emergency treatment of chronic illnesses received outside the United States if performed without pre-authorization.
50. Any drug or other item which does not require a prescription.
51. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
 - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
 - Transportation, travel or lodging expenses for non-donor family members;
 - Donation related services or supplies, including search, associated with organ acquisition and procurement.
 - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
 - Any transplant not specifically listed as covered.
52. Acupuncture and acupuncture therapy.
53. Private room, except as specified as Covered Services.
54. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
55. Court-ordered services, or those required by court order as a condition of parole or probation.
56. Hypnotherapy.
57. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
58. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
59. Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
60. Thermograms and thermography.
61. Private duty nursing services.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another BlueChoice Healthcare Plan BCBSGA plan, any other group medical expense coverage, or any local, state or governmental plan (except school accident insurance coverage or Medicaid), then benefits payable under this Plan will be coordinated with the benefits payable under the other plan. The total benefits paid by both plans will not exceed 100% UCR, the per diem negotiated fee or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. The claim determination period is the Calendar Year.

Coordination of benefits and subrogation of Medicare claims will be administered according to standard Medicare rules and regulations and pursuant to, and also consistent with, the Plan's policies and procedures for Medicare eligible Employees.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- **Automobile Insurance.** Medical benefits available through automobile insurance coverage will be determined before that of any other plan if the automobile coverage has either no order of benefit determination rules or it has rules which differ from those permitted under applicable Georgia Insurance Regulations.
- **Non-Dependent/Dependent.** The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or Divorced.** Except as stated below, when this Plan and another plan cover the same child as a Dependent of different persons, called "**parents**":
 - **The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.**
 - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

BlueChoice Healthcare Plan (HMO)

However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- **Dependent Child/Parents Separated or Divorced.** If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - first, the plan of the parent with custody of the child;
 - then, the plan of the spouse of the parent with custody of the child; and
 - finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or Calendar Year during which any benefits are actually paid or provided before the company has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."
- **Active/Inactive Employee.** The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee or Participant longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary Plan to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plan" below.

Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Miscellaneous Rights

- **Right to Receive and Release Necessary Information.** Certain facts are needed to apply these rules. The Plan have the right to decide which facts are needed. The Plan Administrator may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to pay the claim.
- **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan Administrator will not have to pay that amount again.
- **Right of Reimbursement.** If the amount of the payment made by the Claims Administrator is more than it should have paid under this provision, the Claims Administrator may recover the excess from one or more of:
 - the persons the Claims Administrator has paid or for whom the Claims Administrator has paid,
 - insurance companies, or
 - other organizations.

Subrogation

The Plan reserves the right to be reimbursed for benefits paid under this Plan if the person for whom benefits are paid has a right to recover these benefits from a third party. This is called **subrogation**. This provision helps control the cost of the Plan by limiting certain recoveries to the

BlueChoice Healthcare Plan (HMO)

actual medical expense lost. In no instance shall a Participant be asked to reimburse more than the actual medical expenses paid on the Participant's behalf.

Right of Subrogation If a Participant incurs medical expenses as the result of injuries suffered because of the alleged negligence or misconduct of another person, the Participant may have a claim against that person for payment of medical bills. The Plan will be subrogated to the right of recovery the Participant has against the other person.

This right shall be only to the extent of benefits paid by the Plan for medical expenses. The Participant will be required to reimburse the Plan out of any monies the Participant receives from the other person or his or her insurance company as a result of judgment, settlement or otherwise. The Participant will be required to furnish the Plan information and assistance required to enforce this right of subrogation. The right of subrogation shall not apply to any recovery the Participant obtains from any insurance company under which the Participant is the insured person. The purpose of this provision is to help provide insurance at reasonable rates. Subrogation will be administered by the Claims Administrator.

General Information

Balance Billing

Participating Physicians are prohibited from balance billing. A Participating Physician has signed an agreement with the Claims Administrator to accept the Claims Administrator's determination of the Usual, Customary and Reasonable Fee for Covered Services rendered to a Participant who is his or her patient. A Participant is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, e.g., Copayments or Coinsurance.

Proof of Loss, Payment of Claims

If you incur out-of-area claims, please submit the bill to Blue Cross Blue Shield Healthcare Plan of Georgia. Please include your ID number so the Plan Administrator can verify that you are an active Participant.

Timeliness of Filing and Payment of Claims (Out-of-Area Only)

In the event you submit a claim, to receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In

this case, the Plan Administrator will notify you of the reason for the delay and you will receive a list of all information needed to continue processing your claim. After this data is received, BCBSHP will complete claims processing.

Network Providers

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. provides or makes payment for Medically Necessary covered health care services received by the Participant. The health care services are subject to the limitations, exclusions, and Copayments specified in the SPD Booklet. Unless otherwise specified, all services must be coordinated by the Primary Care Physician you have selected from the BlueChoice provider directory.

Unauthorized Use of Identification Card

If you permit a BCBSHP Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or the BCBSHP Customer Service Department. Be sure to always give your ID number. If you wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

Write

Customer Service Department
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

When asking about a claim, give the following information:

- Identification number;
- Patient's name and address;
- Date of service; type of service received; and
- Provider name and address (Hospital or doctor).

Complaints about Service

As a Participant, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that the fullest attention is given to your concerns.

1. Call the Customer Service Department. The phone number is on your ID Card. Tell BCBSHP your problem and BCBSHP will work to resolve it for you as quickly as possible.

BlueChoice Healthcare Plan (HMO)

2. If you are not satisfied with the answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving the response, you will be offered the right to appeal the decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will, hopefully, bring the matter to a satisfactory conclusion for you.
4. If you remain dissatisfied upon conclusion of the first appeal level, you may again request an appeal of our decision. At the second appeal level, you have the opportunity to represent yourself in a formal Grievance Committee setting to present your own perspective in our concerted effort to bring this matter to a satisfactory resolution.

Complaints about Provider Service

If your complaint involves care received from a provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

The Plan provide the benefits described in this SPD Booklet only for eligible Participants. The health care services are subject to the limitations, exclusions, Copayments, and percentage payable requirements specified in this SPD Booklet. Any group BCBSHP contract or certificate which you received previously will be replaced by this Plan.

Benefit payment for Covered Services or supplies will be made either directly to the Network Hospital (or Network Facility), the Network Physician or to you depending upon whether services were rendered by a Network or Non-Network Provider.

The Plan is not responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person.

In order to process your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by an Employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of your new address.

General Information

Fraudulent statements on Employee application forms and on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Participant's coverage.

The Plan Administrator and the Claims Administrator are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire etc.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Changes in Coverage

The Plan Sponsor may change the benefits described in this SPD Booklet. The Participant will be informed of such a change as required by law

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. BCBSHP will reimburse you

BlueChoice Healthcare Plan (HMO)

directly. Payment will be based on Eligible Charges and based on the UCR of the Participant's legal residence (i. e., local UCR). Assignments of benefits to foreign providers or facilities cannot be honored.

Licensed Controlled Affiliate

The Participant hereby expressly acknowledges his/her understanding that this policy constitutes a contract solely between the Employer and BCBSHP, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSHP to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that BCBSHP is not contracting as the agent of the Association. The Employer further acknowledges and agrees that it has not entered into this Plan based upon representations by any person other than BCBSHP and that no person, entity, or organization other than BCBSHP shall be held accountable or liable to the Participant for any of BCBSHP's obligation to the Participant created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSHP other than those obligations created under other provisions of this agreement.

Calculation of Coinsurance and Other Participant Liability

When you obtain health care services through BlueCard outside the geographic area BCBSHP serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to BCBSHP.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, BCBSHP would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

When Your Coverage Terminates

Termination of Coverage (Group)

BCBSHP may cancel this Plan on the renewal date in the event of any of the following:

1. The Group fails to pay Premiums in accordance with the terms of this Plan.
2. The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
3. The Group has fallen below BCBSHP's minimum employer contribution or group participation rules.
4. BCBSHP terminates, cancels or non-renews all coverage under a particular policy form, provided that:
 - BCBSHP provides at least 90 days notice of the termination of the policy form to all Participants;
 - BCBSHP offers the Group all other small group (employer) or large group (employer) policies, depending on the size of the Group, currently being offered or renewed by BCBSHP for which it is otherwise eligible; and
 - BCBSHP acts uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

Extension of Benefits in Case of Total Disability

If the Group Plan is terminated for non-payment of subscription charges, or if the Group terminates the Plan for any reason; or if the Plan is terminated by BCBSHP (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

Plan benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to twelve (12) months from the date of termination of the Group Plan or to the maximum of the amount payable under this Plan during the extension period.

BlueChoice Healthcare Plan (HMO)

NOTE: BCBSGA considers total disability a condition resulting from disease or Injury where:

- the Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- the Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

Extended Benefits

If a Member's coverage ends and he or she is totally disabled, under a Physician's care, and not covered by another plan of group benefits, BCBSHP extends major medical benefits for that Member under this Plan as explained below. This is done at no cost to the Member.

BCBSHP only extends benefits for Eligible Charges due to the disabling condition. The Eligible Charges must be incurred before the extension ends. What BCBSHP pays is based on all the terms of this Plan.

BCBSHP does not pay for charges due to other conditions. BCBSHP does not pay for charges incurred by other covered Dependents.

The extension ends on the earliest of: (a) the date the total disability ends, or (b) one year from the date the Member's coverage under this Plan ends. It also ends if the Member has reached the payment limit for his or her disabling condition.

NOTE: BCBSHP considers total disability a condition resulting from disease or Injury where the Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit.

Enhanced Conversion Rights

You and/or your Dependents may be a "qualifying eligible individual" for an enhanced conversion product if:

- your most recent coverage was under a group plan or continuation coverage;
- coverage under this Plan has been terminated for any reason other than fraud or failure to pay a required Premium;
- all continuation (COBRA) coverage has been exhausted;
- there is 18 months of prior Creditable Coverage immediately prior to termination;
- you are not eligible for, nor have declined, any of the following:
 1. Any group health policy (including continuation under COBRA or state continuation);
 2. Medicare;
 3. Medicaid or a similar program;

- you are not covered under any other creditable health insurance coverage, including individual or student health coverage.

You must file a substantially completed application for such enhanced conversion coverage, and pay the first Premium, no later than 63 consecutive days after a qualifying event, or the date of notice of enhanced conversion rights, whichever is later.

If you do not qualify for enhanced conversion rights, you may qualify for standard conversion rights as set out below.

Continuation of Coverage (Federal Law-COBRA)

If your coverage ends under the plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits, regardless of whether the Group is insured or self-funded.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Employee during the period of continuation coverage is also eligible for election of continuation coverage.

BlueChoice Healthcare Plan (HMO)

Initial Qualifying Event	Length of Availability of Coverage
<u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Spouses/ Dependents:</u> A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
<u>For Dependents:</u> Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If you are a retiree under this plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the premium rate changes for active associates, your monthly premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar

BlueChoice Healthcare Plan (HMO)

coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Continuation of Coverage (Federal Law – USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Participant may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under the plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 18 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the

Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the plan by reason of the Employee's reinstatement of coverage.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation

BlueChoice Healthcare Plan (HMO)

on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;

- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

Special Requirements for COBRA and Conversion Rights

- COBRA is the first available option for continuing coverage.
- Any COBRA benefits must be exhausted for the entire COBRA eligibility period before conversion coverage will be provided.
- No conversion rights are available if a Member is enrolled or eligible for other group coverage.

Governmental Health Care Programs

(If you are enrolled in a group with fewer than 20 employees, your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program. Such coverage includes Medicare Part A and B and other similar programs. This reduction in payment will be equal to the amount that was paid or would have been paid (if you had been enrolled) by the other program.)

Under federal law, for groups with 20 or more employees, all active employees (regardless of age) can remain on the group's health plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active employees can remain on the group's health plan and receive group benefits as primary coverage.

Direct questions about Medicare eligibility and enrollment to your local Social Security Administration office.

Continuation of Coverage (Age 60 and Over)

An Employee (and eligible Dependents), insured in Georgia under a company's welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Employee was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements which must be met:

- you must have been covered under a group plan which covers 20 or more employees; and
- you must have been continuously enrolled for at least six months under this Plan.

This continuation benefit is not available if:

- your employment is terminated voluntarily for other than health reasons;
- the health plan enrollment was terminated because you failed to pay a Premium or Premium contribution;
- the health plan enrollment is terminated and replaced without interruption by another group Plan;
- health insurance is terminated for the entire class of Employees to which you belong;
- the company terminated health insurance for all Employees; or
- your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (Chapter 8 of Title 34 "Employment Security Law").

The following eligibility requirements apply:

- you must have been 60 years of age or older on the date coverage began under the continuation provision;
- your Dependents are eligible for coverage if you meet the above requirements;
- your spouse and any Covered Dependent children whose coverage would otherwise terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (Premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal Group Member. You must pay the first Premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:

- the date you fail to pay any required Premium when due;
- the date the Group Plan is terminated; (If the Group Plan is replaced, coverage will continue under the new group plan.);
- the date you become insured under any other group health plan; or
- the date you or your divorced or surviving spouse becomes eligible for Medicare.

BlueChoice Healthcare Plan (HMO)

Definitions

Accidental Injury

Bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Affiliation Period

A period used by the Claims Administrator in lieu of a pre-existing condition exclusion clause, beginning on the enrollment date, which must expire before coverage becomes effective. A Participant is not eligible for health care benefits during this period.

After-Hours Office Visit

Care rendered as a result of a condition that has an onset after the Primary Care Physician's business hours.

Applicant

The corporation, partnership, sole proprietorship, other organization or group which applied for this Plan.

Application for Enrollment

The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Application may take the form of an electronic submission.

Brand Name Drugs

A drug item which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: those drugs that are produced by only one manufacturer and do not have a generic equivalent available.
- Multi-Source Brand: those drugs that are produced by multiple pharmaceutical manufacturers and do have generic equivalent available on the market.

Chemical Dependency Treatment Facility

An institution established to care for and treat chemical dependency, on either an Inpatient or outpatient basis, under a prescribed treatment program. The institution must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The institution must be licensed, registered or approved by the appropriate authority of the State of Georgia or must be accredited by the Joint Commission on Accreditation of Hospitals.

Benefit Period

Six months, June 1 – December 31. It does not begin before a Participant's Effective Date. It does not continue after a Participant's coverage ends.

Calendar Year

A period of six months commencing on the Effective Date (July 1, 2005) and ending at 12:00 midnight on the last day of the year (December 31, 2005).

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. was chosen to administer this Plan.

Coinsurance

If a Participant's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Participant is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Limit. Compare to Copayment.

Complications of Pregnancy

Complications of pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but, are adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It

BlueChoice Healthcare Plan (HMO)

avoids claim payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment

A cost-sharing arrangement in which a Participant pays a specified charge for a Covered Service, such as the Copayment indicated in the **Summary of Benefits** for an office visit. The Participant is usually responsible for payment of the Copayment at the time the health care is rendered. Typical Copayments are fixed or variable flat amounts for Physician office visits, Prescription Drugs or Hospital services. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered. Copayments may be collected by the provider of service or the Claims Administrator.

Cosmetic Surgery

Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in an Employee's family who meets all the requirements of the Eligibility section of this SPD Booklets, has enrolled in the BlueChoice Healthcare Plan, and is subject to Premium requirements set forth in this Plan

Covered Services

Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Participant's Plan, (b) not excluded under such Plan, (c) not Experimental or Investigational and (d) provided in accordance with such Plan.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or

Medicaid; (b) an Employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a spouse's benefits or coverage under Medicare or Medicaid or an Employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage as defined in OCGA 33-30-15.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of BCBSHP can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill you must pay before your medical expenses become Eligible Charges. The Deductible is applied on a Calendar Year basis.

Dependent

The Spouse, and all unmarried children until attaining age 19. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your Spouse) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this Plan, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you. In addition, the Plan

BlueChoice Healthcare Plan (HMO)

Administrator does not consider as a Dependent, welfare placement of a foster child under a welfare placement, as long as the welfare agency provides all or part of the child's support.

Children who are students (after high school) in an institution of higher learning at least five months each year (or were prevented from being enrolled due to illness or Injury) remain covered until attaining age 26. Mentally retarded or physically handicapped children remain covered no matter what age. You must give evidence of your child's incapacity within 31 days of attainment of age 19. This proof of incapacity may be required annually by the Claims Administrator. Such children are not eligible under this Plan if they are already 19 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

Direct Access

A Participant has the right to receive services from specified providers without a Primary Care Physician Referral. This is called Direct Access. Such providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist, an optometrist/ophthalmologist for medical conditions only.

Durable Medical Equipment

Equipment, as determined by the Claims Administrator, which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally or use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan Administrator approves an individual application for coverage. For individuals who join this Group after the first enrollment period, the Effective Date is the date the Plan Administrator approves each future Participant according to the normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Participant to a later point in time.

Eligible Charges

Those charges for services and supplies (a) defined as Covered Services and not excluded under the Participant's Plan; (b) that are Medically Necessary; and (c) that are provided in accordance with the Participant's Plan. For In-Network services, Eligible Charges are determined by: (a) BCBSHP's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) BCBSHP's Usual, Customary and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; and or (d) negotiated fees. All payment determinations for Hospital Services are based on the applicable Reimbursement Rate. Reimbursement for Out-of-Network, Participating and Non-Participating Providers is based on Eligible Charges for the type of service a Participant receives, for example, Hospital or Physician services.

Employee

A person who is engaged in active employment with the Group and is eligible for Group coverage with the Plan Sponsor under the employment regulations of the Group.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over

BlueChoice Healthcare Plan (HMO)

those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961(t)(2) of the Social Security Act;
4. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any National board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
6. It meets the Technology Assessment Criteria as determined by the Claims Administrator as outlined in the Definitions Section of this SPD Booklets.

Formulary, BCBSHP Formulary, Preferred Drug Formulary or Drug Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals by the Claims Administrator that may include but not be limited to (1) a listing of preferred prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Participants through pharmacies that are Network Providers, and (2) pre-certification rules. This list is subject to periodic review and modification by the Claims Administrator, at the Claims Administrator's sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Participant selects a medication not included in the Formulary.

Freestanding Ambulatory Facility (Surgi-Center)

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Generic Drugs

Prescription Drugs that are not Brand Name Drugs but which are made up of equivalent ingredients.

Group

The Employee's Employer, which has entered into the Health Plan Document with the Claims Administrator. The Group shall act only as an agent of Participants who are Participants of the Group and their eligible Dependents.

Health Plan Document

This SPD Booklets in conjunction with the Health Plan Document, the Group Master Application, the BCBSHP's Formulary, any amendments or riders, your Identification Card and your Enrollment Application constitutes the entire Plan. If there is any conflict between either this SPD Booklets or the Health Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this SPD Booklet and the Health Plan Document, the Health Plan Document shall control.

Home Health Care

Care, by a state-licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A provider which renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

BlueChoice Healthcare Plan (HMO)

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Participant and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Identification Card

The latest card given to you showing your Identification number and Group number, the type of coverage you have and the date the coverage became effective.

Ineligible Charges

Charges for health care services that are not Eligible Charges because the services are not Medically Necessary or pre-admission certification was not obtained. Such charges are not eligible for payment.

Ineligible Hospital

A facility which does not meet the minimum requirements to become a Participating Hospital. Services rendered to a Participant by such a Hospital are not eligible for payment.

Ineligible Provider

A provider which does not meet the minimum requirements to become a Participating Provider or with whom BCBSHP does not directly contract. Services rendered to a Participant by such a provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Group (or one of that person's eligible Dependents) on the original Effective Date of the Health Plan Document between BCBSHP and the Employer or currently enrolled through the Employer under a BCBSHP Plan.

Injury

Bodily harm from a non-occupational accident.

In-Network Care

Covered Services provided to Participants and appropriately coordinated by the Primary Care Physician through Network Hospital and Network Providers or selected by the Participant from Network Providers for which a Primary Care Physician referral is not required. Such providers include a gynecologist for obstetrical or gynecological – related conditions, a dermatologist, an optometrist/ophthalmologist for medical conditions only.

Inpatient

A Participant who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit

A special unit of a Hospital that: 1. treats patients with serious illnesses or Injuries; 2. can provide special life-saving methods and equipment; 3. admits patients without regard to prognosis; and 4. provides constant observation of patients by a specially trained nursing staff.

Late Enrollees

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/hers initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor covered Dependent under a Participant's Plan, but only as long as the Participant requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage

BlueChoice Healthcare Plan (HMO)

during the initial open enrollment period and did not submit a certification to the Claims Administrator that coverage was declined because other coverage existed.

Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Participant under the Plan.

MCSO-Medical Child Support Order

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Medical Emergency

"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead to prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunctions of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

Medical Facility

Any Hospital, ambulatory care facility, chemical dependency facility, skilled nursing care facility, home health agency or mental health facility, as defined in this SPD Booklets. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary

The Plan Administrator reserve the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered,

recommended or approved a service or supply does not, in itself, make it Medically Necessary.

The Plan Administrator consider a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the doctor, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Mental Health Disorders

Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or chemical dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Care Provider

An institution such as a Hospital or ambulatory care facility established for the diagnosis and treatment of mental illness. The facility must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The facility must be operated in accordance with the laws of the State of Georgia, or accredited by the Joint Commission on Accreditation of Hospitals.

Network Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, BCBSHP to provide services to its Participants; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield HMO BLUE USA Plan.

BlueChoice Healthcare Plan (HMO)

Network Provider

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies in the Service Area that has a Network Provider contract with the Claims Administrator to provide Covered Services to Participants. Also referred to as In-Network Provider.

New Hire

A person who is not employed by the Group on the original Effective Date of the Health Plan Document.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Non-Participating Provider

A Hospital, Physician, Freestanding Ambulatory Facility (Surgi-Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have a Participating Agreement with the Claims Administrator to provide services to its Participants at the time services are rendered.

Out-of-Area Urgent Care

Covered Services required in order to prevent serious deterioration of a Participant's health that results from an unforeseen illness or Injury if the Participant is temporarily absent from the BCBSHP Service Area and receipt of the health care service cannot be delayed until the Participant's return to the Service Area.

Out-of-Network Provider

A Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies, that does not have a Network Provider contract with the Claims Administrator. This provider may also be referred to as a Non-Network Provider.

Out-of-Pocket Limit

The maximum amount of a Participant's Coinsurance payments during a given Calendar Year. Such amount does not include Copayment amounts or fees in excess of Providers' reasonable fees. When the Out-of-Pocket Limit is reached, the level of benefits is increased to 100% of Eligible Charges for Covered Services, exclusive of Copayments and other scheduled fees.

Participant

The Subscriber and each Dependent, as defined in this SPD booklet, while such person is covered by this Plan.

Participating Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, Blue Cross Blue Shield of Georgia, Inc.; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield Plan; or a Hospital outside Georgia located in an area not served by any Blue Cross and Blue Shield Plan.

Participating Provider

A Hospital, Physician, Freestanding Ambulatory Facility (Surgical Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies that has signed a Participating Agreement with BCBSGA to accept its determination of Usual, Customary and Reasonable Fees (UCR) or other payment provisions for Covered Services rendered to a Participant who is his or her patient.

Periodic Health Assessment

A medical examination that provides for age-specific preventive services that improve the health and well-being of a patient being examined. This examination is provided through the network by Primary Care Physicians. The frequency and content of the health assessment are determined by established guidelines and the Participant's personal history.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care. This service could be provided or prescribed, overseen and billed for by the Physician, or given by a physiotherapist on an Inpatient basis on the orders of a licensed Physician and billed by the Hospital.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor or Osteopathy (D.O) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D) are also providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

BlueChoice Healthcare Plan (HMO)

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Plan Sponsor's health benefits.

Plan Administrator

The person named by the Plan Sponsor to manage the Plan and answer questions about Plan details.

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operations, amendments and terminations.

Premium

The amount that the Group or Participant is required to pay the Claims Administrator to continue coverage.

Prescription Drug

A drug which cannot be purchased except with a prescription from a Physician and which must be dispensed by a pharmacist.

Primary Care Physician (PCP)

A licensed Physician who is a Participating Provider trained in general family practice, pediatrics or internal medicine, and has entered into an agreement to coordinate the care of Participants. Your Primary Care Physician provides initial care and basic medical services, assists you in obtaining pre-certification of Medically Necessary Referrals for Specialist and Hospital care, and provides you with continuity of care.

Professional Ambulance Service

A state-licensed emergency vehicle which carries via the public streets injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

QMCSO – Qualified Medical Child Support Order

A QMCSO creates or recognizes a right of a child who is recognized under the order as having the right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

Referral

Specific instructions from a Participant's Primary Care Physician, in conformance with the policies and procedures, that direct a Participant to a In-Network Provider for Medically Necessary care.

Reimbursement Rate

The percentage of Eligible Charges calculated each year by the Claims Administrator and BCBSGA for any In-Network or Participating Hospital. The payment rate will be applied to all Hospital Inpatient and outpatient claims during the payment period, including Out-of-Network and Non-Participating Hospitals.

Respite Care

Care furnished during a period of time when the Participant's family or usual caretaker cannot, or will not attend to the Participant's needs.

Semiprivate Room

A Hospital room which contains two or more beds.

Service Area

Includes counties listed in the appropriate Service Area Map. (Please refer to your Provider Directory.)

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Participant leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

Spinal Manipulation

Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Spouse

For the purpose of this Plan, a spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Employee.

BlueChoice Healthcare Plan (HMO)

Substance Abuse

Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation

Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans.

Technology Assessment Criteria

Five criteria all procedures must meet in order to be Covered Services under this Plan.

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternative.
5. The technology must be beneficial in practice.

Urgent Care Center

A facility, appropriately licensed and meeting BCBSHP standards for an Urgent Care Center, with a staff of Physicians, at which urgently-needed medical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). A Physician's office does not qualify as an Urgent Care Center.

Usual-Customary-Reasonable (UCR) Fees (as determined by the Claims Administrator and approved by the Plan):

Usual Fee: The fee a Physician most frequently receives as reimbursement for the procedure performed.

Customary Fee: Based on a competitive profile of the usual fees received as reimbursement by similar Physicians in a given geographic area for the procedure performed, according to BCBSHP's records.

Reasonable Fee: The fee different from usual or customary fees because of unusual circumstances involving complications requiring additional time, skill and experience.

If it does not pay at contracted rates, the Claims Administrator may pay up to the usual fee not to exceed the customary fee, unless special circumstances or complications occur, in which case the Plan may consider the reasonable fee.

All payments are based on the UCR applicable to the Participant's actual residence (i.e., local UCR).

Utilization Review

A function performed by the Plan Administrator or by an organization or entity selected by the Plan Administrator to review and approve whether the services provided are Medically Necessary, including, but not limited to, whether acute hospitalization, length of stay, outpatient care or diagnostic services are appropriate.

You and your

Refer to the Employee, Participant and each Covered Dependent.

BlueChoice[®]

Healthcare Plan

Administered by Blue Cross Blue Shield
Healthcare Plan of Georgia, an Independent Licensee
of the Blue Cross and Blue Shield Association

GID:July 2004

SMS2049,SMS2149mi052006